



Dear Prospective Junior Volunteer:

We are so excited that you have chosen to volunteer at Stevens Hospital. We hope that you will find your experience interesting, educational and even FUN!

This program will allow you to:

- Assist in the care and comfort of patients at the hospital
- Learn about and experience possible careers in the healthcare field
- Meet new people and make new friends
- Fulfill community service requirements for school

To become a volunteer you must:

- Be at least 14 years old
- Be able to fulfill a one quarter commitment
- Be able to commit to at least one 4 hour shift each week
- Provide three letters of recommendation; at least one of which is from a school staff member
- Complete the required paperwork
- Interview with the Volunteer Services Staff
- Attend a Volunteer Orientation
- Complete a 2-step TB skin test
- Provide proof of immunizations
- Watch videos and complete the required accompanying tests

We have volunteer opportunities in the following areas:

- Admitting
- Information Desk
- Emergency Room
- Gift Shop
- Patient Care Areas

Please complete the enclosed paperwork and return it to the Volunteer Office. Questions? Call the Volunteer Services Office at 425-640-4341; Monday through Friday, 8:00am - 5:00pm

Thank you for your interest in volunteering at Stevens!

Application for Volunteer Services

Instructions: Please complete all sections of this application in detail so we may consider you for volunteering. If a question or blank does not apply to you, write N/A in the space. Upon completion, sign your name in the space provided and return all documents to Stevens Hospital Volunteer Services in the envelope provided.

PLEASE PRINT LEGIBLY IN PEN

Identification Information

Last Name	First Name	Middle Initial	Maiden Name	Social Security Number
Address (Street) (City) (State) (Zip)				Date of Birth
Mailing Address (if different from above)				Telephone ()
Email Address				Cell phone ()

Education/Employment Information – Check All That Apply

- | | |
|--|---|
| Education <input type="checkbox"/> Junior High
<input type="checkbox"/> High School
<input type="checkbox"/> Some College
<input type="checkbox"/> Undergrad Degree
<input type="checkbox"/> Graduate Degree | Employment <input type="checkbox"/> Student
<input type="checkbox"/> Employed
<input type="checkbox"/> Retired
<input type="checkbox"/> Unemployed
<input type="checkbox"/> Other |
|--|---|

Your occupation _____

Are you volunteering for school community service? yes no

Name of school _____ Hours needed _____

Availability – Check All That Apply

Hours		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8am–noon	Morning							
Noon–4pm	Afternoon							
4pm–7pm	Evening							
Other								

References Business / School / Community (other than a relative)

Name/Relationship	Address	Telephone
		()
		()

Please provide the Volunteer Services Office with a reference letter from each of the above.

Interests – please check all that apply

- Hospitality/Ambassador Volunteer
(greeting, reception, escort)
- Administrative Support Volunteer
(clerical, education, computer)
- Gift Shop Volunteer
(sales, clerical)
- Patient Care Area Volunteer
(assist staff, stock rooms, answer call lights, etc.)
- Surgery Liaison Volunteer
(liaison between OR, Recovery, and patient families)
- Cancer Resource Center Volunteer
- Home Craft Volunteer
(sewing, knitting, crocheting)
- Special Events / Projects Volunteer
(on call for event support)
- Other: _____

Have you ever volunteered before? yes no If yes, where? And what did you do?

Why did you leave? _____

Why did you choose Stevens Hospital for your volunteering?

What is most important to you in a volunteer assignment?

Do you have any restrictions that might limit your ability to perform certain volunteer assignments? (lifting, pushing, and standing)

How did you hear about our volunteer program? _____

Emergency Contact Information

Name	Relationship
Home Phone ()	Other phone (work, cell) ()
Physician	Phone ()

I agree to adhere to the hospital's Volunteer Services policies, procedures, and rules to the best of my ability. I agree to participate in the hospital's orientations. I understand that the Director of Volunteer Services or the hospital's Executive Director may terminate my work as a volunteer at any time, and that I may also terminate my work. I also understand all information regarding patients with whom I work is strictly confidential and I shall maintain that confidentiality.

Volunteer Signature

Date

All volunteers 14 through 18 years of age must have the consent of a parent or legal guardian.

Signature of Legal Guardian

Relationship



CONFIDENTIALITY AGREEMENT

Stevens Healthcare employees, volunteers, medical providers, and vendors must make every effort to prevent unauthorized use and disclosure of medical, personal, or other data pertaining to patients, employees, and proprietary hospital operations ("confidential information"). Under no circumstances should confidential information be released or discussed with anyone unless it is in the performance of legitimate job related duties or medical staff functions ("job duties"). To ensure that all Stevens Healthcare employees, volunteers, medical providers and vendors acknowledge their responsibility to protect the privacy and confidentiality of confidential information, please read and sign the following:

1. I acknowledge that all confidential information is confidential and protected against unauthorized viewing, discussion, use and disclosure regardless of format: electronic, written, overheard or observed.
2. I understand that I may view, use, disclose, or copy information only as it relates to the performance of my job duties. Any unauthorized viewing, discussion, use or disclosure of confidential information is a violation of Stevens Healthcare policy and may be a violation of state and federal law. Any such violation may lead to immediate disciplinary action, including termination (or as appropriate to my affiliation with Stevens Healthcare), and possible civil liability and/or criminal charges.
3. I agree not to change, delete or destroy confidential information unless part of my job duties and, if part of my job duties, I agree to follow all established policies in relation to changing, deleting, or destroying confidential information in any form.
4. I agree to use Stevens Healthcare computer based information systems (the "computer systems") for the sole purpose of performing my legitimate job duties.
5. I agree not to use the computer systems to access confidential information on myself, my family, or any other person except when necessary to the performance of my job duties.
6. I understand that the passwords assigned to me to access the computer systems are confidential, and not to be shared with anyone under any circumstances.
7. I agree to use only my assigned password to access the computer systems and that I am responsible for any access to the computer systems using my password as a result of my own negligence or password sharing.
8. I understand that any actions I take in the Computer Systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me.
9. I agree to report any real or potential breach of confidentiality immediately to the administrator on call.
10. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand, and am committed to its principles.
11. I understand that this signed and dated document will become part of Stevens Healthcare records.

Print Name

Dept/Title

Facility

Signature

Date

INFORMATION ON THE CHILD

Child's Name _____

Date of Birth _____

Allergies and Drug Reactions _____

Chronic Illnesses _____

Regular Medications _____

Blood Type _____

Date of Last Tetanus Immunization _____

Other Pertinent Data _____

Child's Physician _____

Physician's Phone Number _____

Parent's or Guardian's Address _____

Parent's or Guardian's Home Phone Number _____

Parent's or Guardian's Work Phone Number _____

Insurance Coverage _____

Group Number _____

Membership Number _____

Employer _____

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

Hospitals may be reluctant to treat or care for children without consent from parents or legal guardians. This can cause problems if the child has a medical emergency when parents or guardians are not readily available to consent.

Complete this form and leave it with the person who is responsible for your child in your absence. In case of a medical emergency, this form should be brought with the child to the hospital.

I, _____, the natural parent/legal
(PLEASE PRINT)
guardian of _____, authorize and consent
(PLEASE PRINT)

to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment and procedures are immediately necessary or advisable in the interest of my child's health and well-being, and it is not advisable to take the time to contact me in advance.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results, possible alternatives, and the risks, complications and anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

Date

Signature of Parent/Guardian

Witness

*Please provide the information requested on
the reverse side of this form.*



21601 76th Avenue West • Edmonds, WA 98026 • (425) 640-4000



STEVENS HOSPITAL
EDMONDS, WA

A two step TB skin test is required as a condition of volunteer work at Stevens Hospital. The tests, which are spaced one to three weeks apart, are given by the hospital free of charge by the employee health nurse. It is the responsibility of the teenage volunteer to have the results read by one of our Employee Health nurses 48 - 72 hours after the test is given. (She looks at the site of the injection on the inside of the arm to determine a positive or negative reaction.) If the skin test is positive or has previously been positive, a chest x-ray is required. If the junior volunteer fails to have it read, he/she would need to have another TB test at the Health department.

Lab work may also be required if you do not have immunization records. If you have questions, call Bobbi or Ruth at (425) 640-4133.

Authorization for TB Testing of a Minor

My son or daughter _____ has my consent to have a TB (tuberculin skin test) and/or lab tests administered at Stevens Hospital.

Date

Parent / Guardian signature



Infectious Disease/Latex Evaluation

Name _____ Dept. _____ Job Title: _____
Social Security # _____ Date Started _____
Date of birth _____ Home Phone# _____ Address: _____

This evaluation will help ensure that as an employee you are not exposed to infectious diseases that would pose undue risk to you, other employees, patients or visitors. This information will be placed in your confidential health file.

Circle if you have had the following diseases?
Date

Hepatitis B	yes	no	_____
Mumps	yes	no	_____
Measles(Rubeola)	yes	no	_____
Rubella	yes	no	_____
Polio	yes	no	_____
Chickenpox	yes	no	_____

Have you ever had a positive TB skin test/PPD? yes no date: _____

*Documentation of the positive skin test date, any prophylactic treatment and a chest x-ray (less than 6 months old) is required. If the documentation is unavailable please contact the Employee Health office for consultation.

Circle if you have had any of the following immunizations? Please send documentation to Employee Health. Documentation is incomplete without official immunization records.

			Date(s) given
Hepatitis B Vaccine	yes	no	_____
Hepatitis A Vaccine	yes	no	_____
MMR(Measles/Mumps/Rubella)	yes	no	_____
Polio	yes	no	_____
Td.(Tetanus/Diphtheria)	yes	no	_____

Are you latex sensitive or do you have a latex allergy. Please explain: _____

Signature

Date

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633



REQUEST FOR CRIMINAL HISTORY INFORMATION CHILD/ADULT ABUSE INFORMATION ACT RCW 43.43.830 THROUGH 43.43.845 (Instructions on Reverse Side)

<p>A REQUESTING AGENCY/ADDRESS</p> <p>Stevens Hospital Agency</p> <p>Attn 21601 76th Avenue West Address</p> <p>Edmonds, WA 98026 City/State/Zip</p> <p>I certify this request is made pursuant to and for the purpose indicated.</p> <table border="0"><tr><td>Authorized Signature</td><td>Date</td></tr><tr><td>Volunteer Services</td><td>(425) 640-4340</td></tr><tr><td>Title</td><td>Area Code/Phone Number</td></tr></table>	Authorized Signature	Date	Volunteer Services	(425) 640-4340	Title	Area Code/Phone Number	<p>B PURPOSE</p> <p>Check appropriate box</p> <p><input type="checkbox"/> Educational School District (ESD)/School District Volunteer – no fee</p> <p><input checked="" type="checkbox"/> Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)</p> <p><input type="checkbox"/> Profit Business/Organization - \$35</p> <p><input type="checkbox"/> Adoptive Parent - \$35</p> <p>Fees: Make payable to Washington State Patrol by check, money order, or business account.</p> <p>Notary letters certifying the results are available upon request. There is an additional \$5.00 processing fee per notary seal.</p> <p>_____ Notarized Letter(s)</p>
Authorized Signature	Date						
Volunteer Services	(425) 640-4340						
Title	Area Code/Phone Number						

C APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name(s): _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Social Security Number: _____ Driver's Lic. Number/State: _____ / _____
(optional)

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

D WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Stevens Hospital
Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

WSP Use Only

Applicant Right Thumb Print (Optional)

**APPLICANT DISCLOSURE; PURSUANT TO RCW 43_43_834
CHILD AND ADULT ABUSE INFORMATION ACT**

Answer YES or NO to each listed item. If the answer is YES to any item, explain in the area provided, indicating the charge or finding, the date, and the court(s) involved.

1. Have you ever been convicted of any crimes against children or other persons, as follows: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree rap; first, second, or third degree rape of a child; first, or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide, first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution?

ANSWER _____ IF YES, EXPLAIN BELOW:

2. Have you ever been convicted of crimes relating to the financial exploitation if the victim was a vulnerable adult, as follows: first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery?

ANSWER _____ IF YES, EXPLAIN BELOW:

3. Have you ever been found in any dependency action under RCW 13.34.030 (2)(b) to have sexually assaulted or exploited any minor or to have physically abused any minor?

ANSWER _____ IF YES, EXPLAIN BELOW:

4. Have you ever been found in any domestic relations proceeding under Title 26RCW to have sexually abused or exploited any minor or to have physically abused any minor?

ANSWER _____ IF YES, EXPLAIN BELOW:

5. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?

ANSWER _____ IF YES, EXPLAIN BELOW:

6. Have you ever been found in any protection proceeding under chapter 74/34 RCW, to have abused or financially exploited a vulnerable adult?

ANSWER _____ IF YES, EXPLAIN BELOW:

We may request from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. If you are hired before that report is available, YOUR EMPLOYMENT WILL BE CONDITIONED UPON RECEIPT OF A SATISFACTORY REPORT.

If a report is requested from the Washington State Patrol criminal identification system, you will be notified of the response within ten days after we receive this report. We will make a copy of the report available to you upon your request.

Pursuant to RCW 9A.17.085, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true, correct and complete. I understand that if I am hired, I can be discharged for any misrepresentation or omission in the above statement.

APPLICANT SIGNATURE _____

DATE AND PLACE _____

WITNESS _____

Business or Organization Stevens Hospital

Address 21727 - 76th Avenue West, Suite 102, Edmonds, WA 98026

MAIL COMPLETED FORM TO:

WASHINGTON STATE PATROL
IDENTIFICATION AND CRIMINAL HISTORY SECTION
PO BOX 42633
OLYMPIA WA 98504-2633

FOR FURTHER INFORMATION, CONTACT THE WASHINGTON STATE PATROL AT:

PHONE: (360) 705-5100

E-MAIL: crimhis@wsp.wa.gov

WSP WEB SITE: <http://www.wsp.wa.gov>

Washington State conviction criminal history record information is available on the Internet using WATCH (Washington Access to Criminal History). You may use an account established by mail or conduct a search using a credit card (Discover, American Express, Visa, or MasterCard). An account application can be printed by accessing WATCH "HELP" files on the Internet. A \$10 fee is charged for each name and date of birth search, regardless of the outcome.

WATCH WEB SITE: <https://watch.wsp.wa.gov>

CHILD/ADULT ABUSE RECORD SEARCH GUIDELINES

Refer to Revised Code of Washington (RCW) 43.43.830-43.43.845 for complete information. Child/Adult Abuse Information Act background checks may be conducted by Washington State businesses, organizations, or individuals. Other states must conduct searches under the Criminal Records Privacy Act, RCW 10.97.

1. *Searches can be conducted only on prospective employees, volunteers, or adoptive parents.*

Background checks can be conducted on prospective employees, volunteers, or adoptive parents who will or may have unsupervised access to children under sixteen years of age, developmentally disabled persons, or vulnerable adults. The background check is for initial employment or engagement decisions only.

Background checks on current employees or volunteers should be done through the Criminal Records Privacy Act, RCW 10.97

2. *Applicants must be notified an inquiry may be made.*

A business or organization shall not make an inquiry to the Washington State Patrol unless the business or organization has notified the applicant, who may be offered a position as an employee or volunteer that an inquiry may be made.

3. *A business or organization must prepare a disclosure statement to be signed by the applicant before a background check may be conducted.*

A business or organization shall require each applicant to disclose whether the applicant has been:

- (a) convicted of any crime;
- (b) had findings made against him or her in any civil adjudicative proceeding;
- (c) has both a conviction and findings made against him or her.

4. *Applicants must be notified of the response.*

The requesting agency shall notify the applicant of the Washington State Patrol's response within ten days after receipt. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints.